TALKING CASEMIX

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THE NEWSLETTER OF THE NATIONAL ALLIED HEALTH CASEMIX COMMITTEE

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The Australian Community-based Health Codeset

This edition of Talking Casemix was prepared by Annette Byron who acted as NAHCC Executive Officer for the period June to September 2002.

The Australian Community-based Health Codeset (The Codeset) is a project designed to produce tools that reflect the activities and support the information management requirements of all types of health services delivered in a community based setting. The Codeset is a comprehensive suite of individual classifications, designed for use in the Australian community-based health environment. It is built around the major subject areas of Issues, Activities, Events, Clients, Service Providers, Physical Resources, Locations, Programs and Outcomes to represent a comprehensive view of community based health information. It was designed to drive the CHIME Information System and was purpose built to achieve this aim.

The Codeset is a prerequisite to describing the client base, activities, resource usage and outcomes of the wide range of community-based health in a consistent and meaningful way. It brings together, for the first time, all the community-based health sector's information classification requirements.

From the perspective of Allied Health, the major chapters of the Codeset revolve around Issue (problems/diagnoses), and Activity (procedures/interventions). The source of the items that make up these chapters was the workshops that were held nationally during the development phase. These workshops included participants from:

- Mental Health
- Community & Primary Care
- Dental Health
- Drug & Alcohol
- Sexual Health
- General Counselling & Support
- Social & Environmental
- Child, Adolescent & Family
- Aged Care, Rehabilitation & Disability

As a result, the Codeset has an extensive representation of issues and activities that are of value and relevance to the Allied Health Sector. Examples of various schemes include:

ISSUE NATURE

Daily Living Issue

DAILY LIVING ISSUE TYPE

Cleaning / housework
Decision making competence issue
Gardening
Home maintenance
Independent living
Laundering
Difficulty in handling legal affairs
Maintaining / developing leisure interests
Maintaining / developing social contact
Meal preparation
Money management
Nutritional access / planning
Personal care / hygiene issue
Physical exercise issue
Physical mobility issue
Problem operating aids / appliances
Safety and security
Shopping assistance
Time management
Other daily living issue

ACTIVITY NATURE

Care and treatment activity

CARE AND TREATMENT ACTIVITY TYPE

Physical therapy

PHYSICAL THERAPY TYPE

Cardiac rehabilitation therapy
Electrophysical agent treatment
Ergonomic treatment
Hydrotherapy / swimming
Manipulation / mobilisation
Massage
Posture management
Relaxation technique
Respiratory therapy
Splinting / orthotic activity
Strapping / taping / bandaging / padding
Traction
Ultrasound therapy
Other physical therapy

The National Centre for Classification in Health (NCCH) has been appointed as Custodian of the Codeset for the initial 2 years. The NCCH is the Australian centre of excellence in health classification

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theory and an expert centre in coding systems. The NCCH is dedicated to developing and publishing classification systems for use in Australian and New Zealand health services and apply international standards for classification, as well as recommending national standards for classifications in health, primarily classifications of diseases and procedures used to reflect morbidity, mortality and health interventions. They develop and promote standards of coding practice, including ethical practice, advise on coding issues, and produce, publish and disseminate information on national coding issues and health classifications.

The Codeset has been implemented within the Community Health Information Management Enterprise (CHIME) application, and has been rolled out into the Hunter Area Health Service as a pilot. The initial feedback has been positive, however, some issues have been raised which the Custodian will address during the course of their tenure. The NCCH is also working closely with the Australian Institute of Health & Welfare (AIHW) with regard to compatibility between the Codeset and National Minimum Data Set (NMDS) items.
Over the next two years, the NCCH will be involved in the following activities:

- Further developing classification schemes
- Managing the project and systems for version control
- Developing a thesaurus, including business rules, to increase the useability of the Codeset
- Developing authorisation and maintenance procedures
- Incorporating authorised additions and revisions to the Codeset
- Managing further development of schemes where refinement is needed
- Identifying and maintaining external codesets (such as ABS codes)
- Disseminating new versions
- Keeping users informed of new developments
- Liaising with stakeholders in various jurisdictions
- Advising and answering queries on usage
- Ensuring that modifications are consistent with appropriate standards
- Relating the Codeset to reporting classifications such as ICD-10-AM.

The NCCH is keen to promote the existence and useability of the Codeset beyond the scope of the CHIME application. Allied Health professionals with an interest in the Codeset are welcome to contact Alex Canduci at A.Canduci@cchs.usyd.edu.au for further information. NAHCC members will also have an opportunity to contribute to the project through a representative to the NCCH.

Indicators for Intervention: Phase 2

NAHCC representatives from five professions, members of the Indicators for Intervention (IFI) working party, and representatives from the Commonwealth Department of Health and Ageing met on July 22 and 23 in Melbourne to plan the next phase of the development of IFIs and to frame a proposal for funding of the project.

You will recall that IFIs are a service provider description of the characteristics of the individual or population which indicate the need for allied health intervention. The need for IFIs was identified when it became clear that the DRG classification did not adequately reflect the contribution of allied health professions to the care of inpatients in the acute care setting. This need was confirmed at the workshop by evidence that various organisations in different care settings around Australia are building on the existing IFI classification or developing classifications of a similar nature as a tool with a number of applications.

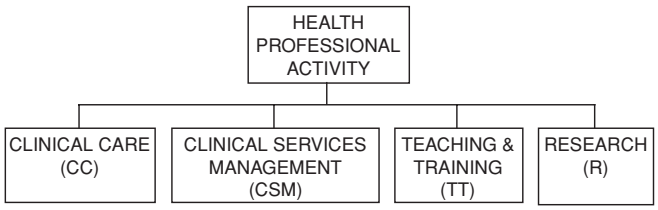
Participants were updated in the early sessions of the workshop on current health issues at the national level, the relationship of IFIs to other classifications and the major features of IFIs. The first IFI project established a template, hierarchical framework and final set of IFIs that had the support of allied health professions in principle, provided further work was done to refine and extend the classification with definitions at each level.

The later sessions of the workshop were allocated to determining what is needed to enhance the IFIs and what project method would best deliver the desired outcome of a refined classification with extended levels and definitions at all levels. There was a strong feeling that project resources should support discussion within and between professions to ensure that each IFI has meaning to potential users. Participants were also enthusiastic about testing IFIs in a wider variety of settings and canvassing the interest of other health care workers in the use of IFIs.

The NAHCC Secretariat is refining the project proposal prepared at the workshop with a view to obtaining funding for Indicators for Intervention: Phase 2 for a period of 12 to 14 months. NAHCC members will have the opportunity to comment on the proposal in early September. In the meantime, the Secretariat would like to hear of any work being done in the area and from sites that might be interested in participating in field trials.

Know Your Health Data – Health Activity Hierarchy

The range of activities provided by allied health professionals in Australia is described in the NAHCC Health Activity Hierarchy Version 1.1. (HAH). The HAH is structured around four main areas ie clinical care, clinical service management, teaching and training, and research. There are a number of levels described in each area.



In the early 1990s, allied health managers realised the importance of defining what allied health professions do during the health care process in order to measure their contribution. The first attempt to establish a hierarchy was one of the outcomes of the NAHCC Reference Standards Project in 1997, along with the Minimum Data Set. More recently, the National Allied Health Benchmarking Consortium has refined the first version and tightened the definitions of activities. A useful addition has been the development of an audit tool based on 48 scenarios which can be used to check compliance of allied health departmental activity data against the HAH. NAHCC has requested that the HAH be included in the National Health Data Dictionary (NHDD). If accepted in the NHDD, this will further support the standardisation of allied health activity reporting.

How is the HAH relevant?

Allied health activity is now acknowledged as one of the fundamental elements in clinical management information systems. When time is also recorded against an activity it provides a rich data source. Managers can use the data to understand the existing resource allocation and predict the implications of changes in practice, whether that change comes from within the allied health department or from the medical or surgical units that act as the referral source. Allied health services can be evaluated in the context of multidisciplinary care when other hospital activity data is considered. This can be very useful from a quality management perspective to ensure that departments are delivering the right services in the most efficient manner.

Managers can also advocate for adequate resources for their department when they can demonstrate the full range of activities that are necessary to meet the needs of patients, other hospital departments, training institutions and other stakeholders. Modern allied health managers know they need more than just occasions of service or individual patient attributable data if they are to manage activity across the 4 major areas.

There is increasing pressure on many departments to take more undergraduates on clinical placements or to contribute to clinical teaching programs. Being in possession of comprehensive activity data enables managers to make choices about how they will deploy their available staff resources and to negotiate with training institutions to fulfil the obligations of both parties.

Another advantage of having activity data collected in a manner which complies with the HAH is that it facilitates comparison of activities when benchmarking services between organizations.

More information

Copies of the NAHCC HAH Version 1.1 can be downloaded from our website at www.bf.rmit.edu.au/nahcc/. The document includes the HAH classification, definitions, the Minimum Data Set and Activity Assignment examples.

HAH activity codes in the Clinical Care (CC) category are based on the ICD-10-AM classification. The table below indicates the number of allied health CC codes captured in the top 10 "allied health" intensive AR-DRG's in hospitals (2000 – 2001).

Number of allied health interventions per separation for the top 10 AR-DRGs with the highest number of allied health interventions per separation, by hospital sector, 2000-01

AR-DRG	AR-DRG description	Public	Private	Total
Z60A	Rehabilitation with Catastrophic or Severe CC	3.0	2.9	3.0
B70A	Stroke with Severe or Complicating Diagnosis/Procedure	2.9	2.0	2.7
W01Z	Ventilation or Craniotomy Procs for Multiple Significant Trauma	2.7	1.8	2.7
Z60B	Rehabilitation without Catastrophic or Severe CC	2.4	2.5	2.4
A06Z	Tracheostomy Any Age Any Cond	2.5	1.5	2.4
Y01Z	Severe Full Thickness Burns	2.3		2.3
S63A	HIV-Related Infection with Catastrophic CC	2.3	1.0	2.3
A03Z	Lung Transplant	2.3		2.3
B02A	Craniotomy with Catastrophic CC	2.5	1.3	2.2
W02Z	Hip, Femur and Limb Procs for Multiple Significant Trauma, incl Implantation	2.1	1.4	2.1

Source: AIHW National Hospital Morbidity Database

Update on the Australian Allied Health Service Weights Project

Substantial progress has been made on the Australian Allied Health Service Weights Project during 2002.

The months of January through to March were a busy time for Project Manager, Catherine Itsiopoulos, and Project Officer, Merlene Koch. The Project Team travelled extensively around the country to run workshops for allied health managers and training workshops for clinicians for the purpose of recruiting hospitals to participate in the study. To date, there are 30 hospitals participating from all States within a range of classes from metropolitan to rural hospitals.

Richard Tate joined the project in July as a consultant with expertise in hospital finance and costing. Richard has been liaising with the clinical costing managers at participating sites to finalise the costing requirements. Hospitals will supply a sample of costed data to confirm that the costing methodology has been appropriately implemented. Actual data collection began on 1 July 2002 and will continue until June 2003 at most sites. A workforce census has been completed by allied health managers to define the allied health staff throughout participating sites for inclusion in the costing.

Allied health managers have also assisted the project by undertaking an audit of their activity data classifications against the Health Activity Hierarchy Version 1.1 (HAH). The HAH audit tool, developed by the National Allied Health Benchmarking Consortium and NAHCC, was used by one head of department, one senior allied health clinician and one base grade member in each department to check compliance with the HAH.

At present, the Project Team is developing a reference manual to be posted on the NAHCC website. This will provide information relating to the background of the project, costing issues, products in scope, data definitions, final costed report data fields and checklists for data deadlines and submission processes.

It should be mentioned that the Project Team appreciates the significant co-operation given by the costing managers and allied health staff from the hospitals participating in the project despite their busy schedules.

State	*NSW*	*VIC*	*SA*	*QLD*	*TAS*	*WA*
Hospital class	5 large metropolitan 2 principal referral 2 acute specialist 2 large district 3 small district	4 large metropolitan 1 medium metropolitan 1 large regional	2 large metropolitan	3 large metropolitan 1 large rural	1 large metropolitan	3 large metropolitan
Total	**14**	**6**	**2**	**4**	**1**	**3**

Rural and Remote Allied Health on the Move

Great news story! The National Rural and Remote Allied Health Advisory Service (NRRAHAS) has taken up residence at the offices of the National Rural Health Alliance in Canberra.

The energy that has been applied to promoting awareness of allied health within the political arena resulted in the office of Rural Health (Department of Health and Ageing) allocating funds to Allied Health. Ideas to create a service like NRRAHAS have been in the planning stages for many years, so there is lots of enthusiasm surrounding its establishment.

Essentially, NRRAHAS will build support for rural and remote allied health service providers. The service will ensure that issues associated with rural and remote allied health professionals and services are included on important health and workforce agendas currently being addressed in Australia.

NARRHAS is being established by the two peak bodies for rural and remote allied health professionals – Services for Australian Rural and Remote Allied Health (SARRAH) and the Health Professions Council of Australia (HPCA) through its Australian Rural and Remote Allied Health Taskforce (ARRAHT). SARRAH membership consists of individual allied health professionals across rural and remote Australia. ARRAHT is the rural and remote voice of the Allied Health Professional Associations that are members of the HPCA.

Ann O'Kane has been appointed as the National Project Officer for NRRAHAS. Ann has substantial experience in project management, policy development and has also spent many years out bush as an allied health professional (both in rural areas of Victoria and remote areas of the Northern Territory). Ann is keen to hear from rural and remote allied health professionals and other key stakeholders who are interested in the potential of NRRAHAS.

There is a significant amount of preliminary work that needs to be undertaken. NARRAHS will be establishing a clearing house of all relevant rural and remote allied health information that has been documented by many people from all over Australia – some reports have been published, others heave been used to guide policy and program decisions. Work will commence to identify the major gaps in service provision and good ideas that have succeeded in terms of recruitment and retention of allied health professionals.

The NRRAHAS will be working closely with a range of stakeholders including employers (State/Territory health departments), professional associations, the Commonwealth government and other organisations and groups supporting the rural and remote health workforce.

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Outcome Measures for the Allied Health Professions

Queensland NAHCC members (Queensland Council of Allied Health Professions) make progress through a professional development one-day seminar.

A seminar entitled *"Outcome Measures for the Allied Health Professions"* was held in Brisbane on 17 May 2002. The objective of the seminar, organised by the Queensland Council of Allied Health Professions (QCAHP) was to provide information and experience in defining outcomes from professional interventions which can be objectively evaluated in terms of costs/benefits for patients and providers. Information on current work in developing outcome measures would be provided, as well as the opportunity for hands-on experience in developing a model/process for clinical application. Interest was very high, with 117 attending from 10 professions and a substantial further number wishing to attend but by necessity, declined registration because of capacity limitations of the venue. Clearly, outcome measures are a topic, which needs to be addressed in both national and local forums and through high quality research by allied health professionals.

With this in mind, we were delighted to welcome as speakers both David Stokes, an Executive member of NAHCC, who has been coordinating planning for NAHCC's ongoing performance measure work and also Alison Perry, whose exciting research project *"AusTOMs"* aims to produce a valid and reliable measure of therapy outcomes. NAHCC is a member of the reference group for the AusTOM study and has been keen to cooperate with this important project.

David Stokes, who has recently been appointed as Manager, Professional Practice, the Australian Psychological Society, presented the history and objectives of quality and performance measurement work within the Commonwealth and State government frameworks, also providing examples of national clinical indicators which are relevant to allied health. In outlining the progress of NAHCC IFI and PI work within this context, he brought new insights to many Queensland allied health professionals.

Professor Alison Perry from La Trobe University and her research assistant, doctoral student Jemma Skeat, outlined the development of AusTOMs: Australian Therapy Outcome Measures, for the professions of Occupational Therapy, Speech Pathology and Physiotherapy. Although based on the UK TOM work, there has been susbstantial development within the Australian context. Some allied health clinicians from Queensland were already involved in data collections, and on the seminar day, workshop participants from all professions were able to contribute to the project through a SWOT analysis.

Our third and fourth speakers were Margaret Shapiro and Deborah Setterlund from the University of Queensland, who, in conjunction with three Brisbane metropolitan hospital social work departments, are developing and trialing an outcome directed model of practice. This model will be evaluated with the use of new outcome measures for social work, currently being developed by a doctoral student.

Margaret Tweeddale, Manager of the Domiciliary Allied Health Acute care and Rehabilitation Team (DAART) at the Mater Hospitals, Brisbane, spoke of outcome measures in her service. Margaret has been able to combine system or service outcome measurement with client focussed outcome measurement in her highly successful service, which clearly demonstrates the value adding of allied health interventions. Her work provides an inspiration to allied health professionals seeking to demonstrate clear outcomes from high-level professional services.

Margaret also facilitated a workshop in which seven interdisciplinary groups each analysed a different case scenario to produce appropriate goals, outcome measures and performance indicators for different 'customers', within both the funder/referrer and patient/client systems. All the earlier presenters acted as facilitators to the groups and provided constructive feedback on the analysis done by the groups in their application of learning from earlier in the day. David Stokes encouraged us all not to be afraid to "commit to a measure" and have confidence to "make a clinical judgement" on this.

Finally, single discipline groups met to begin considering how their respective professions could further their use of the material provided. It was recognised that this would need to be consolidated by follow up sessions arranged by the professions themselves. The plan is for the Queensland Council of Allied Health Professions to assist in facilitating this ongoing process in conjunction with NAHCC initiatives.

Overall, evaluation of the workshop was positive with all objectives being met to some degree. Provision of information on current work in developing outcome measures and the hands-on experience of developing a model for clinical application was particularly appreciated. Interestingly, learning how to add value to the service system and demonstrate this was the most problematic, with less confidence in this aspect following the seminar, by comparison with value adding for the patient/client or team. Perhaps this is a message for us all as we continue our outcome measurement work.

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Tasmanian Allied Health Casemix Group

The Tasmanian Allied Health Casemix Group is represented on NAHCC by Fred Howard (Podiatry Manager – Royal Hobart Hospital).

There is presently a number of IT projects underway in Tasmania. The impact of some of these projects will be on the way data is managed in the State. Some of the major projects include the Statewide Client Registration Project (SCRP), Community Client Health Profile (CCHP) and Hospital Information System replacement (HIS).

The State-wide Client Registration Project
The creation of a statewide index of Department of Health and Human Services (DHHS) is seen as central to the capability of pulling together information relevant to an individual as well as managing an efficient, statewide health system. Phase 1, due for completion in the third quarter 2002, will take the demographic information from the 3 major state hospitals and generate a unique identifier for each individual across the state acute care setting, enabling quicker transfer of information where an individual presents to a public hospital different to their original point of registration. The better management of waiting lists and other efficiencies will also be realised.

Community Client Health Profile
Services in the community setting are delivered through a network of Community Health Centres and related facilities. This complex and dispersed range of health and wellbeing programs have not previously been linked by a cohesive and comprehensive information management system. It is this role that CCHP is designed to play.

Currently, the CCHP is being completed for a trial implementation in the north of the State. The CCHP will provide the capabilities to manage individuals across Allied Health services, improve management reporting and provide operational facilities to streamline service delivery.

Phase 2 of the SCRP will link the client index to the CCHP introducing consistency across most DHHS services, ultimately enabling direct transfer and coordination of care across the acute and community health sectors.

Hospital Information System replacement (HIS)
Due to its age and the imminent cessation of vendor support, the current hospital information system in each of the 3 major public hospitals must be replaced. This presents an opportunity to implement a unified, state-wide hospital information system that will take advantage of the work done by SCRP.

Outcome Measures *continued from page 6*

The gratitude of QCAHP's professional development committee, Bevan Wiltshire, Ann Edwards and Mary Haire, together with QCAHP's President, Dr Betty Headley and QCAHP members, is extended to all the speakers and facilitators, who gave so freely of their time and advice, both in preparation for the seminar and on the day.

QCAHP and allied health professionals generally in Queensland would be pleased to hear about similar seminars organised in other states/territories and to share ideas about the way forward.

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